

Health, Welfare, Public Service
 300
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 diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

FILED AUG 1 - 1957

STATE FILE NUMBER 24829
 3088

Registration District No. 149 Primary Registration District No. 1002 Registrar's No.

1. PLACE OF DEATH a. COUNTY Jackson				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Linn					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN Linneus		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Joseph Hosp			Length of stay in 1b 4 days		d. STREET ADDRESS (If outside, give location) R.R. 1		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First NOLAN Middle FORRESTER Last SINGLETON				4. DATE OF DEATH Month July Day 2nd Year 1957					
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-3-1898		9. AGE (In years last birthday) 49 48		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Linn Co. Missouri		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Charley Singleton				14. MOTHER'S MAIDEN NAME Rosie Alexander					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO. 549-03-6347		17. INFORMANT Address Mrs. Dorothy Singleton, Wife, Linneus Mo.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subarachnoid Hemorrhage; Intracerebral Hemorrhage								INTERVAL BETWEEN ONSET AND DEATH 6/30/57 - 7/2/57	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) Cerebrum Circle Willis						330X	
DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NONE								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.									
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY		STATE	
21. I attended the deceased from 6-30-57 to 7-2-57 and last saw her/him alive on 7-2-57 Death occurred at 11:30 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE Robert W. Forsythe, M.D. (Degree or title)					22b. ADDRESS 411 Nichols Rd. KC, Mo			22c. DATE SIGNED 7-3-57	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)				
Burial		July 5-1957	Laclede Cemetery		Laclede Missouri				
24. FUNERAL DIRECTOR Mrs. C.L. Forster Funeral Home, Inc.				25. DATE RECD. BY LOCAL REG. 7-3-57		26. REGISTRAR'S SIGNATURE Neva Minshall			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
 Robert W. Forsythe

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed
by me, or by....., Student Embalmer No.....
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed

John V. Herick

Licensed Embalmer No.....40

P. O. Address *P. O. No.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.